

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

03976

1. PLACE OF DEATH:

County.....Dorchester
City or town.....Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....40 years
Hospital, institution, or street address where death occurred:
8 Park Lane
How long in hospital or institution?.....1111

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....Maryland County.....Dorchester
City or town.....Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 Park Lane
(If rural, give LOCATION)
2.(a) If veteran, name war.....11111111

3. (a) FULL NAME

Hattie A. Ashby

3. (b) Social Security Number

None

4. Sex.....Female
5. Color or race.....Colored
6. (a) Single, married, widowed, or divorced.....Married
6. (b) Name of husband or wife.....George W. Ashby
6. (c) If alive, give age.....65 years
7. Birth date of deceased (mo., day, yr.).....January 19, 1882
8. AGE: Year 65 Months 3 Days 17 It less than one day.....hrs. min.

9. Birthplace.....Ewell-Somerset-Md.
(Town, county, and state)
10. Usual occupation.....Housewife
11. Industry or business.....Home
FATHER
12. Name.....Judson Sutton
13. Birthplace.....?
MOTHER
14. Maiden name.....Harrietta ?
15. Birthplace.....Accomac, Va.
16. Informant.....Rev. G. W. Ashby
Address.....Cambridge, Md.

Burial
17. (Burial, cremation, or removal, Which?).....Date thereof.....May 8, 1947
(month) (day) (year)
Cemetery or crematory.....Lawsonia Cemetery
Location.....Crisfield, Md.
18. Funeral director.....H. Harvey Bradshaw
Address.....Crisfield, Md.

19. May 12th 47 John M. [Signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 5, 1947, at 9:30 P.M.
21. I CERTIFY that death occurred on the date above elated; that I attended deceased from May 1, 1947, to May 5, 1947, and that I last saw him alive on May 4, 1947.
Immediate cause of death.....Cerebral Hemorrhage
DURATION.....4
Due to.....Sen. Hypertension
Due to.....Acute Encephalitis
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide.....Date of.....
Where did injury occur?.....(City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury.....Injured at work?

23. SIGNATURE.....Corrall M. St. Clair, M.D.
M. D. or other
Address.....P.O. Box 10, Cambridge, Md. signed 5/7/47

RECEIVED

MAY 13 1947

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 406 Trenton Street				d. STREET ADDRESS 406 Trenton Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Eva		Middle P.		Last BARNES	
		4. DATE OF DEATH		Month May		Day 14	
				Year 19 47			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-12-63		9. AGE (In years lost birthday) 84 yrs.	
				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) New York State		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Washburn				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Own records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arterio sclerotic cardio vascular renal disease 6 yrs. + DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1-2 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Angina Pectoris						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -- --					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. -- 19				20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- --	
				20f. (City or town) -- --		(County) -- --	
						(State) -- --	
21. I certify that I attended the deceased from 1-5-47 , 19 47 , to 5-14-47 , 19 47 , that I last saw the deceased alive on 4-28-47 , 19 47 , and that death occurred at 3:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md. DATE SIGNED 9-15-58							
ACTUAL SIGNATURE <i>Eldridge H. Wolff</i>		M.D. 15 Locust Street, Cambridge, Md.					
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-17-47		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>LeCompte</i>				24a. REC'D. BY REGISTRAR DATE SEP 23 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	
LeCompte Funeral Service Cambridge, Md.							

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03977

CERTIFICATE OF DEATH

Reg. Diat. No. 116

1. PLACE OF DEATH:

County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, institution, or street address where death occurred
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. Pine ST
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Mary Fisher Brown

3. (b) Social Security Number

4. Sex F Color or race N. A. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife William Brown

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1863

8. AGE: 83 Years 10 Months 8 Days If less than one day

9. Birthplace Old field - near creek
town, county, and state

10. Usual occupation General labor

11. Informant Robert Brown

12. Name Robert Brown

13. Birthplace Tork neck

14. Maiden name Sarah J. Fisher

15. Birthplace Old field - near creek

16. Informant German Fishers

Address 6 Cambridge Md

17. Burial Date thereof 5 17 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Vienna Md

18. Funeral director L. St. B. Ayneum

Address 201 Wash St.

19. May 15 - 47 John Mace Jr. Md
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1947 at 12:00 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1947 to May 13, 1947

and that I last saw her alive on May 5, 1947

Immediate cause of death hepatic uremia DURATION 3 days

Due to hepatic, arterio-sclerotic

Due to unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lawrence Mangano M.D. M.D. or other

Address 66 Race St. Date signed 5/13/47
Cambridge

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAY 16 1947

BUREAU

5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03978

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:

County Dorchester
 City or town Federalburg - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
Reliance Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Federalburg - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Reliance Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John J. Burke

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife -
 6.(c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) February 21, 1869
 8. AGE: Years 78 Months 2 Days 28 It less than one day hrs. min.

9. Birthplace Philadelphia, Pennsylvania
 (Town, county, and state)
 10. Usual occupation Day laborer
 11. Industry or business Canning Factory
 FATHER 12. Name No data available
 13. Birthplace
 MOTHER 14. Maiden name No data available
 15. Birthplace

16. Informant Mrs. D. Milled Spadlin
 Address Federalburg, Maryland
 17. Burial Date thereof May 22, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Hill Cross Cemetery
 Location Federalburg, Maryland
 18. Funeral director F. J. Fraughton & Son
 Address Federalburg, Maryland
 19. May 22 19 47 Charles H. Hastings
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 19 47 at 12 noon
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 19 47 to May 19 19 47
 and that I last saw him alive on 5/19 19 47
 Immediate cause of death Chronic myocarditis
 DURATION ?
 Due to
 Due to
 Other conditions Chronic induration 10 yrs.
 (Include pregnancy within 5 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Frank M. Anderson M.D.
Federalburg, Md. M. D. or other
 Address Date signed 5/22

RECEIVED

MAY 31 1947

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 03979

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? -

Hospital, institution, or street address where death occurred:

Byrn St.How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. Byrn St.
(If rural, give LOCATION)2.(a) If veteran, name war -

3. (a) FULL NAME

James Nichles Dawson Cantwell

3. (b) Social Security Number

-

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Married</u>

6. (b) Name of husband or wife Rosa Albrighton-1904

Fannie Adkins 63 years

7. Birth date of deceased (mo., day, yr.) April 11, 1875

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>-</u>	<u>28</u>	<u>-</u> hrs. <u>-</u> min.

9. Birthplace Castle Haven, Dor. Co., Md.
(Town, county, and state)10. Usual occupation Waterman11. Industry or business Seafood12. Name James F. Cantwell13. Birthplace Maryland14. Maiden name Rebecca Kinney15. Birthplace Maryland16. Informant Mrs. Fannie CantwellAddress Byrn St., Cambridge, Md.17. Burial Date thereof May 12, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cambridge CemeteryLocation Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. 5-12-47 John Mass Jr Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 19 47 at 9:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 - to 19 -and that I last saw h. in alive on May 9, 19 47Immediate cause of death Coronary Thrombosis DURATIONDue to Hypertension

Due to

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter E. Huntz M.D. M. D. or otherAddress 105 CHURCH ST. Date signed 10 MAY '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 13 1947

BUREAU 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is, especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

03980

1. PLACE OF DEATH: Morshokotes
 County Cambridge
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? entire life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Morshokotes
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war none

3. (a) FULL NAME Lester L. Cooke

3. (b) Social Security Number
214-07-8219

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Amelia Dodson
 6. (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) July 7 - 1912

8. AGE: Years 34 Months 10 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Cambridge
 (Town, county, and state)

10. Usual occupation Manager of Canning Factory

11. Industry or business Clarice Cooke

12. Name Clarice Cooke

13. Birthplace Clar. Co.

14. Maiden name Helen Thomas

15. Birthplace Cambridge

16. Informant Mrs. Amelia H. Cooke

Address 306, Henry St.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 5-17-1947
 (month) (day) (year)

Cemetery or crematorium Greenlawn
Cambridge, Md
 Location Kenneth R. Thomas
 18. Funeral director Cambridge, Md
 Address

19. May 17 19 47 John Mass Jr Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 - 1947 at 6 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Injury to Brain

Due to Pistol shot through right temple

Due to X

Other conditions X

(Include pregnancy within 8 months of death)

Major findings of operations X Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

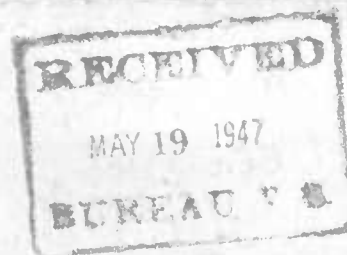
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide suicide Date of May 14/47

Where did injury occur? Cambridge - Md
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at canning factory

Means of injury Pistol shot Injured at work? No

23. SIGNATURE Dr. B. Shriver, Dep. Med. Exam.
 M. D. or other
 Address Cambridge - Md Date signed May 15/47



Evidence for additon of
usual residence of deceased
shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03981

FIL NO G 110 JUN 5 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

47

5-24-47

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 21

1947

at 8:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

DURATION

Chronic Myocarditis 6 mo

Due to

Due to

Other conditions

X

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 30 1947

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of residence is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03982

FILM No. G 110 JUN 10 1947 CERTIFICATE OF DEATH

Reg. Dist. No. 111

1. PLACE OF DEATH:

County Baltimore
City or town East New Market.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Dorchester

City or town East New Market
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

William R. Deane

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed or divorced

Male White Single

8.(b) Name of husband or wife

7. Birth data of deceased (mo., day, yr.) April 6 1870
6.(c) If alive, give age _____ years

8. AGE: Years 77 Months 11 Days 24
If less than one day _____ hrs. _____ min.

9. Birthplace (Town, county and state)

10. Usual occupation Painter

11. Industry or business

12. Name James Deane13. Birthplace Md.14. Maiden name Emily Ross15. Birthplace Md.16. Informant Mary HicksAddress East New Market17. Burial, cremation, or removal, Which? Burial Date thereof June 1st 1947

(month) (day) (year)

Cemetery or crematory CemeteryLocation East New Market18. Funeral director F.B. WilloughbyAddress East New Market19. May 31 1947 Registrar Elyse C. Smith

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946 to May 29 1947
and that I last saw him alive on May 28 1947

Immediate cause of death Pneumonia
Influenza

Due to Arthritis, ChronicDue to Diabetes mellitus

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R.D. Brown, M.D.Address East New Market Date signed 5/31/47

M. D. or other

RECEIVED

JUN 4 1947

BUREAU 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

CERTIFICATE OF DEATH

Reg. Dist. No. 0398316

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life (3 hours)
 Hospital, institution, or street address where death occurred:
Cambridge Maryland Hospital
 How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 216 West End Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war -

3. (a) FULL NAME

"Infant" Devos

3. (b) Social Security Number

-

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Infant

6. (b) Name of husband or wife

-

6. (c) If alive, give age

-

7. Birth date of
deceased (mo., day, yr.)

May 16, 1947

8. AGE:

Years

Months

Days

If less than one day

-

-

-

3

hrs.

0

min.

9. Birthplace Cambridge, Maryland

(Town, county, and state)

10. Usual occupation

-

11. Industry or business

-

FATHER
MOTHER12. Name Henry Stepaen Devos13. Birthplace Belgian14. Maiden name Margaret Hauch15. Birthplace Virginia, U.S.A.16. Informant Mr. Henry S. DevosAddress Cambridge, Maryland17. Burial Date thereof May 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenlawn CemeteryLocation Cambridge, Maryland18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. May 17 19 47 John Mace Jr. M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 19 47 at 9:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 16 19 47 to May 16 19 47
and that I last saw him/her alive on May 16 19 47

Immediate cause of death

Prematurity (22 weeks)
wgt. 1 lb. 0 oz.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Eldridge Hubert

M.D. or other

Address

Cambridge, MD

Date signed

May 17 1947

RECEIVED

MAY 22 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

139a

03984

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County..... Worcester
 City or town..... Cambridge
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 18 days

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?..... 18 days

3. (a) FULL NAME

4. Sex..... F 5. Color or race..... Colored 6. (a) Single, married, widowed, or divorced..... married

6. (b) Name of husband or wife..... Colman Ennels

7. Birth date of deceased (mo., day, yr.)..... July 18 1909 6. (c) If alive, give age..... 41 years

8. AGE: Years..... 37 Months..... 10 Days..... If less than one day..... hrs. min.

9. Birthplace..... Linn's Road

(Town, county, and state)

10. Usual occupation..... Gen. Labor

11. Industry or business.....

12. Name..... Leh Todd13. Birthplace..... Linn's Road14. Maiden name..... Sarah E. Traves15. Birthplace..... Linn's Road16. Informant..... Lillian JohnsonAddress..... Craps md.17. (Burial, cremation, or removal. Which?)..... Burial Date thereof..... 5 16 47

(month) (day) (year)

Cemetery or crematory..... CrapsLocation..... Worcester, Co.18. Funeral director..... A. H. BayneAddress..... 201 Washington19. May 15 1947 John Mac Jr. M.D. Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... md. County..... WorcesterCity or town..... Craps md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 11, 1947 at 7 50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 23, 1947 to May 11, 1947and that last saw him alive on May 11, 1947

Immediate cause of death.....

DURATION

Peritonitis 2 wks

Due to.....

pelvic abscess

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Lawrence Wemyer

M. D. or other

Address..... 136 Race St. Date signed..... 5/13/47Cambridge md.

RECEIVED

MAY 16 1947

BE NEAL 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03985

Reg. Dist. No. 16

1. PLACE OF DEATH:

County.....Dorchester
 City or town.....Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....5 years 7 months 4 days
 Hospital, institution, or street address where death occurred:
 Eastern Shore State Hospital
 How long in hospital or institution?.....5 years 7 months 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....Maryland County.....Wicomico
 City or town.....Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....unknown
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Anna W. Feeks

3. (b) Social Security Number

none

4. Sex.....Female 5. Color or race.....White 6. (a) Single, married, widowed, or divorced.....Widowed
 6. (b) Name of husband or wife.....Glendon Feeks
 6. (c) If alive, give age.....years
 7. Birth date of deceased (mo., day, yr.).....January 16 1864

8. AGE: Years.....83 Months.....3 Days.....16 It less than one day.....hrs. min.

9. Birthplace.....Bangor Maine
 (Town, county, and state)

10. Usual occupation.....Domestic

11. Industry or business.....Private homes

12. Name.....Robert Wyer

13. Birthplace.....Maine

14. Maiden name.....Celinda Casey

15. Birthplace.....Ireland

16. Informant.....Hospital Records

Address.....Cambridge, Maryland

17. Burial.....Date thereat.....May 5, 1947
 (Burial, cremation, or removal. Which?).....(month) (day) (year)

Cemetery or crematory.....Greenlawn Cemetery

Location.....Cambridge, Maryland

18. Funeral director.....LeCompte's Funeral Service

Address.....Cambridge, Maryland.

19. 5/5 19. 47
 (Date rec'd by registrar).....Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 2 1947 at 10.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 September 28 1941 to May 2 1947

and that I last saw her alive on May 2 1947

Immediate cause of death.....DURATION

Arteriosclerotic cardiovascular disease.....3 years

Due to.....

Senility

Due to.....

Other condition.....Senile Psychosis 6 years

(Include pregnancy within 3 months of death)

Major findings of operations.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....Injured at work?

23. SIGNATURE.....M.D. or other

Address.....Cambridge, Maryland Date signed.....5/2/47

RECEIVED

MAY 7 1947

BUREAU 78

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03986

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 56 Years
 Hospital, institution, or street address where death occurred:
407 Byrn St.
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 407 Byrn St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME

Minnie Jahn Gerlach

3. (b) Social Security Number

—

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife John George Gerlach
Died 3/31/1928 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 25, 1860

8. AGE: Years 87 Months 2 Days 6 If less than one day — hrs. — min.

9. Birthplace Greenfield, Mass.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Domestic

12. Name Not Known

13. Birthplace " "

14. Maiden name Not Known

15. Birthplace " "

16. Informant Mrs. Omro G. Hearn,

Address Cambridge, Maryland

17. Burial Date thereof June 3, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cambridge Cemetery

Location Cambridge, Maryland

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. June 3rd 1947 John M. ...
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1947 at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to May 31, 1947
 and that I last saw her alive on May 31, 1947

Immediate cause of death Generalized arterio sclerosis DURATION unknown

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE L. O. Meredith M. D. or other —

Address Cambridge, Maryland Date signed June 3, 1947

RECEIVED
JUN 4 1947
BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03987

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 years, 12 days

Hospital, institution, or street address where death occurred:

Eastern Shore State HospitalHow long in hospital or institution? 7 years, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County WicomicoCity or town Sharptown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Leslie A. Grant

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 28, 19038. AGE: Years Months Days If less than one day
43 11 _____ hrs. _____ min.9. Birthplace Lexington, Green County, New York
(Town, county, and state)10. Usual occupation Laborer on farms11. Industry or business Business12. Name Arden A. Grant13. Birthplace New York State14. Maiden name Lizzie P. Decker15. Birthplace New York State16. Informant Eastern Shore State Hospital RecordsAddress Cambridge, Maryland17. Burial Date thereof 5-29-1947
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetary or crematory FiremansLocation Sharptown Md18. Funeral director Graves BrosAddress Sharptown19. May 29 - 47 John Mares Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26th, 19 47. 5:00 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14th, 19 40 to May 26th, 19 47.
and that I last saw him in alive on May 26th, 19 47.Immediate cause of death Broncho Pneumonia
[6/27/47 - ahc]

DURATION

3 do.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, lodge, public place (where?) WicomicoMeans of injury Sharptown Injured at work? _____23. SIGNATURE John Mares M. D. or otherAddress Sharptown Date signed 5/27/47

47. 2:00 P.

May 30th,

47.

May 30th,

40

May 30th,

May 14th,
1.1m

RECEIVED
MAY 31 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03988

Reg. Dist. No. 110

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County HarlockCity or town Hurlock
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas Daniel Harper

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 25 1880

8. AGE:

Years 66Months 11Days 17

If less than one day

hrs. min.

9. Birthplace

Ind
(Town, county, and state)

10. Usual occupation

Insurance Collector

11. Industry or business

Thomas B. Harper

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal) Which?

Date thereof May 11, 1947

(month) (day) (year)

Cemetery or crematory

Hurlock

Location

Rt. 3, Killbuck, Ind.

18. Funeral director

Address

19. May 111947

(Date rec'd by registrar)

Charles W. Hastings

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarlockCity or town Hurlock
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 1946 to May 8 1947and that I last saw him alive on May 7 1947

Immediate cause of death

Coronary thrombosisGeneral arteriosclerosisDue to 1 yr +

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

W. J. Harrison MDHurlock Ind

M. D. or other

Date signed 5/10/47

RECEIVED

MAY 19 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 112

1. PLACE OF DEATH:
 County Northchester
 City or town Vienna
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Southester
 City or town Vienna
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
Clarence Higgins
 4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) April 13, 1872
 8. AGE: Years 75 Months 1 Days 1 If less than one day hrs. min.

9. Birthplace MD (Town, county, and state)
 10. Usual occupation Retired Farmer
 11. Industry or business same
 12. Name Samuel Higgins
 13. Birthplace MD
 14. Maiden name Josephine Elbert
 15. Birthplace MD

16. Informant Mrs. Clarence Higgins
 Address Vienna
 17. Burial Date thereof May 30, 1947
 (Burial, cremation, or removal Which?) (month) (day) (year)
 Cemetery or crematorium Cemetery
 Location Cambridge

18. Funeral director F. B. Willenborg
 Address East New Market
 19. June 5, 1947 Elizabeth D. Bess
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1947 at 10 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to May 28 1947
 and that I last saw him alive on May 28 1947
 Immediate cause of death Metastatic Carcinoma DURATION 2 yrs
 Due to Adenocarcinoma
Pelvis Rt Kidney 5 yrs
 Due to
 Other conditions Arteriosclerosis
Arteriosclerosis
 (Include pregnancy within 8 months of death)
 Major findings of operation Adenocarcinoma
Pelvis Kidney Date of op. 2 years ago
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?
 23. SIGNATURE H. J. Bess M. I. or other
Cambridge Address Date signed 12/47

RECEIVED

JUN 7 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03989

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:
Phillips St. Ext.
 How long in hospital or institution? X

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Phillips St. ext.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

John Holland

3. (b) Social Security Number

4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Ruth Holland
 6.(c) If alive, give age 25 years
 7. Birth date of deceased (mo., day, yr.) about 1899
 8. AGE: Years 48 Months X Days X If less than one day
about hrs. min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business Canning House
 12. Name not known
 13. Birthplace X
 14. Maiden name not known
 15. Birthplace X

16. Informant Ruth Holland
 Address Phillips St. ext. Cambridge, Md.
 17. Burial Date thereof May 3 / 47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cemetery
Cambridge and District City
 Location Levin H. Bayne
 18. Funeral director Levin H. Bayne
 Address Cambridge

19. June 3 - 47 John Macfarlane
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1947 6-30P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
X to X
 and that I last saw him X alive on X 1947

Immediate cause of death

Hemoptysis

DURATION

X

Due to Myocardial Degeneration
and valvular conditions

several
months

Due to Arterio-sclerosis

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Dr. H. Shriver M. D. or other

Address Cambridge, Md. Date signed May 23/47

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JUN 4 1947

BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03990

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Rural-Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
RFD # 3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 102 Locust St.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Daniel L. Hubbard

3. (b) Social Security Number

-

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single8. (b) Name of husband or wife x
Infant7. Birth date of deceased (mo., day, yr.) 19428. AGE: Years 5 Months - Days - If less than one day
.....hrs.min.9. Birthplace Cleveland Ohio
(Town, county, and state)10. Usual occupation - x11. Industry or business - x12. Name Richard C. Hubbard13. Birthplace Maryland14. Maiden name Dorothy Byrne15. Birthplace Ohio16. Informant Richard C. HubbardAddress Cambridge, Md.17. (Burial, cremation, or removal. Which?) Date thereof.....
(month) (day) (year)Cemetery or crematory Barretts ChapelFredericca Del.

Location

18. Funeral director LeCompte Funeral Service.Address Cambridge, Md.19. May 12 - 1947 John W. Maw Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 19 47, at 10 30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

Injury to Brain - due to fracture of base of skull -

Due to.....

Fracture left femur +

Due to.....

left clavicle.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of May 10/47Where did injury occur? Roads Do. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) on State RoadMeans of Injury Automobile Injured at work? No23. SIGNATURE Dr. H. Shriver, Dep. Med Exam

M. D. or other

Address Cambridge - Md Date signed May 11/47

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MAY 13 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03991

1. PLACE OF DEATH: County <u>Dorchester</u> City or town <u>Taylors Island</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>Drowned, Slaughter Creek.</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md.</u> County <u>Dor.</u> City or town <u>Golden Hill</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) <u>World War 11</u> 2.(a) If veteran, name war _____			
3. (a) FULL NAME <u>Cecil M. Jenkins</u>				3. (b) Social Security Number			
4. Sex <u>male</u>		5. Color or race <u>white</u>		6. (a) Single, married, widowed, or divorced <u>single</u>			
6. (b) Name of husband or wife _____							
7. Birth date of deceased (mo., day, yr.) <u>June 9, 1924.</u>							
6. (c) If alive, give age _____ years							
8. AGE: Years <u>22</u>		Months <u>11</u>		Days <u>16</u>			
If less than one day _____ hrs. _____ min.							
9. Birthplace <u>Golden Hill, Md.</u> (Town, county, and state)							
10. Usual occupation <u>Farmer-waterman</u>							
11. Industry or business							
12. Name <u>Alonza M. Jenkins</u>							
13. Birthplace <u>Md.</u>							
14. Maiden name <u>Pearl Riggins</u>							
15. Birthplace <u>Md.</u>							
16. Informant <u>Mrs. Alonza Jenkins</u> <u>Golden Hill, Md.</u> Address _____							
17. burial (Burial, cremation, or removal. Which?) <u>5/27/47/</u> (month) (day) (year) Cemetery or crematory <u>Dorchester Memorial Park</u> <u>Cambridge, Md.</u> Location <u>Le Compte Funeral Service</u> <u>Cambridge, Md.</u>							
18. Funeral director <u>Cambridge, Md.</u> Address _____							
19. <u>May 24 - 19 47</u> <u>John Macfar</u> (Date rec'd by registrar) Registrar							
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>May 25</u> 19 <u>47</u> at <u>11-25 A</u>							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____ and that I last saw him _____ alive on _____ 19____							
Immediate cause of death <u>Drowning - (Accidental)</u>							
Due to _____							
Due to _____							
Other conditions _____							
(Include pregnancy within 3 months of death)							
Major findings of operations _____							
Date of op. _____							
Autopsy results _____							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following:							
Accident, suicide, or homicide <u>accident</u> Date of <u>May 25/47</u>							
Where did injury occur? <u>M. Taylors Island - Dor - Md</u> (City or town) (County) (State)							
Injured at home, farm, industry, public place (where?) <u>Slaughter Creek</u>							
Means of injury <u>drowning</u> Injured at work? <u>No</u>							
23. SIGNATURE <u>Dr. H. Shriver - Dep. Med. Exam.</u> M. D. or other _____							
Address <u>Cambridge, Md.</u> Date signed <u>May 28/47</u>							

RECEIVED
MAY 31 1947
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03992

Reg. Dist. No. 110

1. PLACE OF DEATH:

County Dorchester
 City or town Federalsburg - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
near Williamsburg
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town Oxford
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Barry Wendell Jones

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

February 2, 1943

8. AGE:

Years

Months

Days

If less than one day

4314

hrs.

min.

9. Birthplace

Greenwood, Delaware
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER
MOTHER

12. Name

Jasper L. Jones

13. Birthplace

Thomasville, Georgia

14. Maiden name

Isabelle Wieding

15. Birthplace

Bivalve, Maryland

16. Informant

son Jasper L. Jones

Address

Oxford, Maryland

17. (Burial, cremation, or removal, Which?)

BuriedDate thereof May 18, 1947
(month) (day) (year)

Cemetery or crematory

Bivalve

Location

Bivalve Md

18. Funeral director

Wannic E. Newman sons

Address

Easton Md

19. (Date rec'd by registrar)

May 17, 1947

19

47Charles W. Heston
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1947 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19_____, to _____ 19_____and that I last saw him _____ alive on _____ 19_____

Immediate cause of death

Injury to Brain

DURATION

Due to

Crushing of Skull

Due to

Rear wheel of truck ran over head.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of May 16/47Where did injury occur? m. Federalsburg - Dor. (City or town) Ind. (County) Ind. (State)Injured at home, farm, industry, public place (where?) farmMeans of injury AutomobileInjured at work? No

23. SIGNATURE

Dr. H. Shriver, Dep. Med Examiner
M. D. or otherAddress Cambridge - Md Date signed May 16/47

RECEIVED

MAY 19 1947

BUREAU V 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03993

116

Reg. Diat. No.

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Three Weeks

Hospital, institution, or street address where death occurred:

Cambridge Maryland Hospital

How long in hospital or institution? Three Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Rural-East New Market
 (If outside city or town limits, write RURAL and give nearest town)

Street No. East New Market
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Emma Tuttle Lowe

3. (b) Social Security Number

-

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Daniel C. Lowe

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1890

8. AGE: Years 56 Months 6 Days 3 If less than one day
hrs.min.

9. Birthplace Salem, Dor. Co., Maryland.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Home

FATHER 12. Name Robert Phillips

13. Birthplace Maryland

MOTHER 14. Maiden name Grace Kinnamon

15. Birthplace Maryland

16. Informant Mr. Daniel C. Lowe

Address East New Market, Md.

17. Burial Date thereof June 1, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Salem Church Cemetery

Location Salem, Dor. Co., Maryland.

18. Funeral director LeCompt's Funeral Service

Address Cambridge, Maryland.

19. 5-31-47 Jan Macfarland
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1947, at 6:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 9, 1947 to May 29, 1947
 and that I last saw her alive on May 29, 1947

Immediate cause of death Myocardial Failure DURATION 1 Mo.

Due to advanced arteriosclerosis generalized 6 Mo. +

Due to Diabetes mellitus 2 yrs +

Other conditions Arteriosclerotic 3 Mo. +
gangrene Rt. Foot
 (Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eldridge Hubert M.D. or other
 Address Cambridge, Md. Date signed 5-31-47

RECEIVED

JUN 2 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03994

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Cambridge Maryland Hospital

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. Boundary Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Peggy Ann McGrath

3. (b) Social Security Number

-

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1947

8. AGE: Years - Months 3 Days 25 If less than one day
..... hrs. min.

9. Birthplace Cambridge, Dor. Co., Md.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name E. Eldridge McGrath

13. Birthplace Maryland

MOTHER 14. Maiden name Grace Todd

15. Birthplace Maryland

16. Informant Mr. E. Eldridge McGrath

Address Cambridge, Maryland

17. Burial Date thereof May 23, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dorchester Memorial Park

Location Cambridge, Maryland

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. May 23, 1947 John Macpherson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1947, 5:50A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 20, 1947 to May 21, 1947

and that I last saw her alive on May 21, 1947

Immediate cause of death.....

Acute dilatation Heart DURATION 4 hours

Due to Acute bronchial obstruction

Due to Acute Pneumonia 1 day

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following No

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. J. Banks M. D. or other

Address Cambridge Md. Date signed 5/22/47

RECEIVED

MAY 26 1947

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

03995

CERTIFICATE OF DEATH

Reg. Dist. No. 115

1. PLACE OF DEATH:

County Worcester
City or town Rock Creek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
City or town Rock Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #1
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

John Aron Meekins

3. (b) Social Security Number

NO

4. Sex M 5. Color or race negro 6.(a) Single, married, widowed, or divorced widow

6.(b) Name of husband or wife Mary Rose Meekins
Deceased 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 1, 1887

8. AGE: Years 60 Months 2 Days 16 If less than one day — hrs. — min.

9. Birthplace Meekins Neck Md
(Town, county, and state)

10. Usual occupation Gen labor

11. Industry or business

12. Name John Meekins

13. Birthplace Golden Hill

14. Maiden name Mary Langel

15. Birthplace Golden Hill

16. Informant William Meekins

Address Rock Md

17. Burial Date thereof 5/18/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or Meekins Neck

Location Meekins Neck, Md.

18. Funeral director L. H. Bayne

Address 201 Wash St - City

19. May 18 19 47
(Date rec'd by registrar) Registrar John W. Meekins

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 19 47 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45 to May 16 19 47

and that I last saw him alive on May 16 19 47

Immediate cause of death Cardio-Renal-Vascular DURATION 15 years

Chronic Hypertension

Due to (obstruction)

Cardiac Insufficiency

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

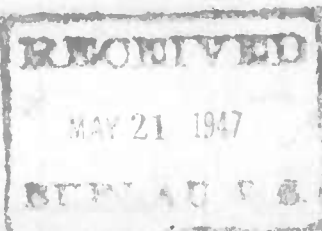
23. SIGNATURE James Meekins M. D. or other

Address Fishing Creek Md Date signed May 18/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



03996

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Diat. No. 116

1. PLACE OF DEATH:

County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Cambridge Md. Hospital

How long in hospital or institution?

1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 211 Academy St.
(If rural, give LOCATION)2. (a) If veteran, name war World War # I

3. (a) FULL NAME

John T. Moore

3. (b) Social Security Number

218-16-8287

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

none

7. Birth date of

deceased (mo., day, yr.)

Nov-20-1892

8. AGE:

54

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Cambridge

(Town, county, and state)

10. Usual occupation

Tailor

11. Industry or business

clothing repairs

FATHER

12. Name

C. Richard Moore

13. Birthplace

Boy Co.

MOTHER

14. Maiden name

Laura Jane Bondley

15. Birthplace

Cambridge

16. Informant

Nannie C. Moore

Address

211 Academy St. Cambridge, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

5-14-1947
(month) (day) (year)

Cemetery or crematory

Cambridge Cemetery

Location

Cambridge, Md.

18. Funeral director

Kenneth P. Shawman

Address

Cambridge, Md.

19.

(Date rec'd by registrar)

May 14 47John Moore & son
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 12 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 1947 to May 12 1947and that I last saw him alive on May 11 1947

Immediate cause of death

Cerebral accident

DURATION

36 hours

Due to

Due to

Other conditions Diabetes mellitus (?) 36 hrs

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Eldridge H. Dreffus
M. D. or otherAddress Cambridge Md. Date signed 5-14-47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 16 1947
BUREAU 98

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

03997

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:

County Dorchester
 City or town Vienna - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2 years
 Hospital, institution, or street address where death occurred:
Reid's Grove
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Vienna - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Reid's Grove
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John A. Murphy

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Elizabeth E. Murphy
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 9, 1862
 8. AGE: Years 84 Months 7 Days 6 It less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 13 1947 to May 15 1947
 and that I last saw him alive on May 14 1947

Immediate cause of death Gastric Ulcer

DURATION

3 day

Due to _____

Due to _____

Other conditions Arterio Sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE J. S. Kuhlman M. D. or other _____Address Shapton and Date signed 5/16/479. Birthplace Brookview Dorchester County, Maryland
(Town, county, and state)10. Usual occupation Waterman11. Industry or business Boat and Seafood12. Name Thomas H. Murphy13. Birthplace Dorchester County, Maryland14. Maiden name Mary E. Walker15. Birthplace Dorchester County, Maryland16. Informant Mrs. Joseph E. BellAddress Vienna, Maryland, R.F.D.17. Burial Date thereof May 18, 1947

(Burial, cremation, or removal. Which?) _____ (month) (day) (year)

Cemetery or crematory Brookview CemeteryLocation Brookview, Maryland18. Funeral director J. J. Frampton and SonAddress Federalburg, Maryland19. May 17 - 1947 Charles H. Hattaway

(Date rec'd by registrar) _____ Registrar

RECEIVED

MAY 26 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03998

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 68 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 234 High Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Fauntleroy Newman

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Amelia Newman

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29 18568. AGE: Years 90 Months 5 Days 14 If less than one day
hrs. min.9. Birthplace West Virginia
(Town, county, and state)10. Usual occupation Gen Laborer

11. Industry or business

12. Name Russel M. Newman13. Birthplace West Virginia14. Maiden name Apatha Miller15. Birthplace West Virginia16. Informant Menerva NewmanAddress Cambridge, Md.17. Burial Date thereof May 18 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wauah CemeteryLocation Cambridge Md.18. Funeral director J. N. Ballance & SonAddress Cambridge Md.19. May 15 - 47 John Macfarlane M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947 at 10:50 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/17 1947 to May 8 1947and that I last saw him alive on April 21 1947Immediate cause of death myocardial failureDue to arterio scleroticHeart DiseaseDue to unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

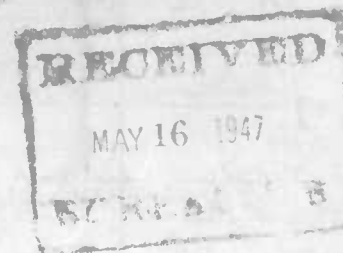
Means of injury Injured at work?

Signature L. Harganov M.D.Address 136 Race St.Date signed 5/13/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03999

CERTIFICATE OF DEATH

Reg. Dist. No. 111

1. PLACE OF DEATH: **Dorchester**
 County.....
 City or town **East NewMarket** (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **10 yrs.**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? **X**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State **Maryland** County **Dorchester**
 City or town **East NewMarket** (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **X**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Charles Wesley Sampson

3. (b) Social Security Number

4. Sex **male** 5. Color or race **colored** 6.(a) Single, married, widowed, or divorced **widowed**
 8. (b) Name of husband or wife **Annie Young (deceased)**
 7. Birth date of deceased (mo., day, yr.) **Mar 19th 1877?**
 8. AGE: Years **70** Months **5** Days If less than one day hrs. min.

9. Birthplace **Dorchester County, Md.**
 (Town, county, and state)
 10. Usual occupation **Laborer**
 11. Industry or business **Farm etc.**
 FATHER 12. Name **Jacob Sampson**
 13. Birthplace **Md.**
 MOTHER 14. Maiden name **Mary Jackson**
 15. Birthplace **Md.**

16. Informant **Morris E. Dockins**
 Address **East NewMarket**
 17. **Burial** Date thereof **MAY 7 1947**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory **Cemetery**
 Location **East New Market**
F. B. Milbrough
 18. Funeral director **East New Market**
 Address **East New Market**
 19. **May 6** 19 **47** **Elizabeth C. Smiley**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **May 4 1947** at **1 P.M.**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **X** 19... to **X** 19...
 and that I last saw him alive on **X** 19...
 Immediate cause of death **Chronic Myocarditis**
several months
 Due to **Arterio-Sclerosis**
 Due to **X**
 Other conditions **X**
 (Include pregnancy within 3 months of death)
 Major findings of operations **X**
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external cause, fill in the following:
 Accident, suicide, or homicide **X** Date of **X**
 Where did injury occur? **X** (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) **X**
 Means of injury **X** Injured at work? **X**
 23. SIGNATURE **J. K. Shriver, Dep. Med. Exam.**
 M. D. or other
 Address **Cambridge, Md.** Date signed **May 4/47**

RECEIVED

MAY 12 1947

BUREAU 3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04000

Reg. Dist. No. 119

1. PLACE OF DEATH:

County Dorchester
 City or town Rural-Wingate
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Years
 Hospital, institution, or street address where death occurred:
Wingate
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Rural-Wingate
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Wingate
 (If rural, give LOCATION)
 2. (a) If veteran, name war -

3. (a) FULL NAME

Charles Fred Smith

3. (b) Social Security Number

-

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Sarah Dean Smith
 6. (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1870

8. AGE: Years 77 Months 4 Days 11 If less than one day
hrs.min.

9. Birthplace Brooklyn, New York
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business New York Central Railroad

FATHER 12. Name Not Known
 13. Birthplace " "

MOTHER 14. Maiden name Not Known
 15. Birthplace " "

16. Informant Mrs. Charles F. Smith
 Address Wingate, Maryland.

17. Burial Burial Date thereof May 27, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Greenlawn Cemetery
 Location Cambridge, Maryland.

18. Funeral director LeCompte's Funeral Service
 Address Cambridge, Maryland.

19. May 27 47 Wilson & Pritchett
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 19 47, at 3: A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1947, to May 24 1947
 and that I last saw him alive on May 24 1947

Immediate cause of death Coronary Heart Failure DURATION 1 mo

Due to arteriosclerosis general

Due to arteriosclerosis general

Other conditions arteriosclerosis due to 100
starvation
 (Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results -
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

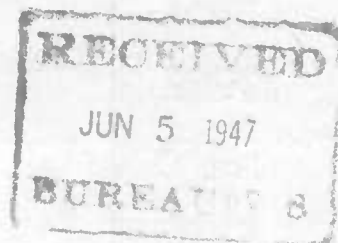
Means of injury - Injured at work? -

23. SIGNATURE James A. Thompson MD M. D. or other
Cambridge, Md Address May 27 Date signed

MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

04001

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? several hrs.
 Hospital, institution, or street address where death occurred:
Cambridge Md. Hospital
 How long in hospital or institution? several hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 115 Pine Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Baby Wilson

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced
 6.(b) Name of husband or wife
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) May 10 1947
 8. AGE: Years Months Days Several less than one day hrs. min.

9. Birthplace Cambridge
 (Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER
 12. Name Francis Wilson
 13. Birthplace Cambridge Dor. Co., Md.
 14. Maiden name Cursell Elliott
 15. Birthplace Cambridge, Dor. Co., Md.

16. Informant Francis WilsonAddress Cambridge Dor. Co. Md

17. Burial Date thereof May 12 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cordtown Dor. Co. MdLocation Cordtown Dor. Co. Md18. Funeral director W. M. St. Clair & SonAddress Cambridge Md

19. May 12 47 Registrar
 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 47 at 9:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/10 19 47 to 5/10 19 47
 and that I last saw him alive on 5/10 19 47

Immediate cause of death Remittent and remittent
 Due to date of expectancy July 5, 1947

Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: none
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other
 Address Cambridge Md Date signed 5/10/47

RECEIVED

MAY 16 1947

BUREAU 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

04002

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Several hrs
 Hospital, institution, or street address where death occurred:
Cambridge Md Hospital
 How long in hospital or institution? Several hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)
 State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 115 Pine Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

2nd Baby Wilson

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 10 1947
 8. AGE: Years _____ Months _____ Days _____ If less than one day
Several hrs
 hrs. _____ min.

9. Birthplace Cambridge, Md
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Francis Wilson
 13. Birthplace Cambridge, Dor. Co. Md
 MOTHER 14. Maiden name Curse Elliott
 15. Birthplace Cambridge, Dor. Co. Md

16. Informant Francis WilsonAddress Cambridge Dor. Co. Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 12 1947
 (month) (day) (year)

Cemetery or crematory CordtownLocation Cordtown Dor. Co. Md.18. Funeral director H M SallanAddress Cambridge Md.

19. May 17 1947 (Date rec'd by registrar) John Mance Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 11 1947, at 4:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/10 1947, to 5/11 1947, and that I last saw h. 17 alive on 5/11 1947.

Immediate cause of death Immaturity and Prematurity
 Due to Date of Expectorate birth July 1947

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following. None
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H M Sallan M. D. or otherAddress Cambridge Md Date signed 5/11/47

RECEIVED

MAY 16 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Lakesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Lakesville
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Lakesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Lakesville
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Mary Catherine Wroten

3. (b) Social Security Number

-

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Chas. Edward Wroten
Died 1/27/1945 6.(c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) Dec. 6, 1871
 8. AGE: Years 75 Months 5 Days 4 If less than one day - hrs. - min.

9. Birthplace Lakesville, Dor. Co., Md.
 (Town, county, and state)

10. Usual occupation -11. Industry or business -12. Name George W. Willey13. Birthplace Maryland14. Maiden name Mary E. Foxwell15. Birthplace Maryland16. Informant Mrs. Sangston DixonAddress Lakesville, Maryland.

17. Burial Date thereof May 12, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Haddaway CemeteryLocation Lakesville, Dor. Co., Md.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.

19. May 12 1947 James W. Mease
 (Date rec'd by registrar) LOCAL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4, 1947 to May 10, 1947
 and that I last saw him alive on May 10, 1947

Immediate cause of death Hypertension and Cerebral Hemorrhage
 Due to -
 Due to Cerebro Rinal Vascular Disease
 Other conditions -
 (Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of Injury - Injured at work? -

23. SIGNATURE James W. Mease M.D.
 M. D. or other -

Address Fishing Creek Date signed May 12/47

RECEIVED

MAY 17 1947

RECEIVED